		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0042499

Facility Name: MCKINLEY COURT

Address: 500 WEST MCKINLEY AVE. (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (847) 875-0020 **Fax #** (847) 875-9434

IDPA ID Number: 36-4121313

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,364	2,877	6,396	14,637	8
9	SNF/PED					9
10	ICF	23,948	12,836	1,069	37,853	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,312	15,713	7,465	52,490	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.87%

D. How many bed-hold days during this year were paid by Public Aid?
410 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 5,838

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	218,915	26,830	10,643	256,388		256,388	1,923	258,311			1
2	Food Purchase		198,401		198,401		198,401	(1,847)	196,554			2
3	Housekeeping	179,054	31,483		210,537		210,537	222	210,759			3
4	Laundry	91,702	24,005	1,589	117,296		117,296	(160)	117,136			4
5	Heat and Other Utilities			132,366	132,366		132,366		132,366			5
6	Maintenance	36,073	20,201	58,089	114,363		114,363	2,197	116,560			6
7	Other (specify):*			13,501	13,501		13,501		13,501			7
8	**TOTAL General Services**	525,744	300,920	216,188	1,042,852		1,042,852	2,335	1,045,187			8
	B. Health Care and Programs											
9	Medical Director			28,260	28,260		28,260		28,260			9
10	Nursing and Medical Records	1,482,664	108,887	18,340	1,609,891		1,609,891	9,444	1,619,335			10
10a	Therapy	90,811		6,538	97,349		97,349		97,349			10a
11	Activities	114,691	3,080	11,987	129,758		129,758	844	130,602			11
12	Social Services	38,742		2,831	41,573		41,573		41,573			12
13	Nurse Aide Training											13
14	Program Transportation			38	38		38		38			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,726,908	111,967	67,994	1,906,869		1,906,869	10,288	1,917,157			16
	C. General Administration											
17	Administrative	73,816		518,892	592,708		592,708	(500,633)	92,075			17
18	Directors Fees											18
19	Professional Services			182,588	182,588		182,588	75,223	257,811			19
20	Dues, Fees, Subscriptions & Promotions			56,349	56,349		56,349	(40,906)	15,443			20
21	Clerical & General Office Expenses	115,139	23,882	60,774	199,795		199,795	116,011	315,806			21
22	Employee Benefits & Payroll Taxes			511,267	511,267		511,267		511,267			22
23	Inservice Training & Education			5,396	5,396		5,396		5,396			23
24	Travel and Seminar			3,569	3,569		3,569	8,049	11,618			24
25	Other Admin. Staff Transportation			2,892	2,892		2,892		2,892			25
26	Insurance-Prop.Liab.Malpractice			125,321	125,321		125,321	39,456	164,777			26
27	Other (specify):*											27
28	**TOTAL General Administration**	188,955	23,882	1,467,048	1,679,885		1,679,885	(302,800)	1,377,085			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,441,607	436,769	1,751,230	4,629,606		4,629,606	(290,177)	4,339,429			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,792	41,792		41,792	224,830	266,622			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,155	97,155		97,155	232,551	329,706			32
33	Real Estate Taxes			(17,056)	(17,056)		(17,056)		(17,056)			33
34	Rent-Facility & Grounds			506,442	506,442		506,442	(491,419)	15,023			34
35	Rent-Equipment & Vehicles			20,741	20,741		20,741	6,929	27,670			35
36	Other (specify):* STORAGE			2,332	2,332		2,332		2,332			36
37	TOTAL Ownership			651,406	651,406		651,406	(27,109)	624,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,471	342,279	466,750		466,750		466,750			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		124,471	424,404	548,875		548,875		548,875			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,441,607	561,240	2,827,040	5,829,887		5,829,887	(317,286)	5,512,601			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,443)	30		9
10	Interest and Other Investment Income	(68,488)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,847)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(588)	21		18
19	Entertainment	(18,289)	20		19
20	Contributions	(5,200)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,305)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(15,417)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,450)	20		28
29	Other-Attach Schedule SEE PAGE 5A	7,046			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,981)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(192,305)	PG 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (192,305)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (317,286)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MCKINLEY COURT

ID# 0042499

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2,469	6	1
2	VACATION ACCRUAL	1,923	1	2
3	VACATION ACCRUAL	222	3	3
4	VACATION ACCRUAL	(160)	4	4
5	VACATION ACCRUAL	(272)	6	5
6	VACATION ACCRUAL	(651)	10	6
7	VACATION ACCRUAL	844	11	7
8	VACATION ACCRUAL	2,837	17	8
9	VACATION ACCRUAL	(166)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	7,046		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT # 0042499 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	1,923	0	0	0	0	0	0	0	0	0	0	1,923	1
2	Food Purchase	(1,847)	0	0	0	0	0	0	0	0	0	0	(1,847)	2
3	Housekeeping	222	0	0	0	0	0	0	0	0	0	0	222	3
4	Laundry	(160)	0	0	0	0	0	0	0	0	0	0	(160)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,197	0	0	0	0	0	0	0	0	0	0	2,197	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,335	0	0	0	0	0	0	0	0	0	0	2,335	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(651)	10,095	0	0	0	0	0	0	0	0	0	9,444	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	844	0	0	0	0	0	0	0	0	0	0	844	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	193	10,095	0	0	0	0	0	0	0	0	0	10,288	16
	C. General Administration													
17	Administrative	2,837	(503,470)	0	0	0	0	0	0	0	0	0	(500,633)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,305)	5,015	71,513	0	0	0	0	0	0	0	0	75,223	19
20	Fees, Subscriptions & Promotions	(42,356)	1,450	0	0	0	0	0	0	0	0	0	(40,906)	20
21	Clerical & General Office Expenses	(754)	116,765	0	0	0	0	0	0	0	0	0	116,011	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,049	0	0	0	0	0	0	0	0	0	8,049	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,689	34,767	0	0	0	0	0	0	0	0	39,456	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,578)	(367,502)	106,280	0	0	0	0	0	0	0	0	(302,800)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,050)	(357,407)	106,280	0	0	0	0	0	0	0	0	(290,177)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MCKINLEY COURT **#** 0042499 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(17,443)	5,481	236,792	0	0	0	0	0	0	0	0	224,830	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(68,488)	0	301,039	0	0	0	0	0	0	0	0	232,551	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	15,023	(506,442)	0	0	0	0	0	0	0	0	(491,419)	34
35	Rent-Equipment & Vehicles	0	6,929	0	0	0	0	0	0	0	0	0	6,929	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(85,931)	27,433	31,389	0	0	0	0	0	0	0	0	(27,109)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(124,981)	(329,974)	137,669	0	0	0	0	0	0	0	0	(317,286)	45

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE, IL	
				MCKINLEY AVENUE LLC		
					MORTON GROVE, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 10,095	$ 10,095	1
2	V	17	ADMINISTRATIVE	518,892	MR. BELLOWS OWNS 62.5% OF THIS FACILITY		15,422	(503,470)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		5,015	5,015	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,450	1,450	4
5	V	21	CLERICAL		" "		116,765	116,765	5
6	V	24	TRAVEL		" "		8,049	8,049	6
7	V	26	INSURANCE		" "		4,689	4,689	7
8	V	30	DEPRECIATION		" "		5,481	5,481	8
9	V	34	RENT		" "		15,023	15,023	9
10	V	35	RENT-EQUIPMENT & VEH		" "		6,929	6,929	10
11	V								11
12	V								12
13	V								13
14	Total			$ 518,892			$ 188,918	$ * (329,974)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 506,442	MCKINLEY AVENUE LLC		$	$ (506,442)	15
16	V	19	ACCOUNTING FEES		" "		2,250	2,250	16
17	V	19	OTHER PROFESSIONAL		" "		69,263	69,263	17
18	V	26	INSURANCE - MORTGAGE		" "		34,767	34,767	18
19	V	30	DEPRECIATION - BLDG/IMPROV.		" "		182,792	182,792	19
20	V	30	DEPRECIATION - EQPT		" "		54,000	54,000	20
21	V	32	AMORTIZATION - MTG COST				8,466	8,466	21
22	V	32	INTEREST - MORTGAGE				284,689	284,689	22
23	V	32	INTEREST - OTHER				7,884	7,884	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 506,442			$ 644,111	$ * 137,669	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMIN.	0.63	SEE ATTACHED	2.56	10.57	SALARY	15,422	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,422		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	52,490	$ 10,095	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	52,490	15,422	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		52,490	5,015	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		52,490	1,450	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		52,490	20,152	5
6	21	CLERICAL	DIRECT COST	1	1	96,613	96,613	1	96,613	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		52,490	8,049	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		52,490	4,689	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		52,490	5,481	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		52,490	15,023	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	496,459	9	65,539		52,490	6,929	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 969,637	$ 337,956		$ 188,918	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - MCKINLEY AVE LLC						$	$			$	1
2	AMERICAN NATIONAL BNK		X	MORTGAGE	VARIES	02/97	4,000,000	PAID OFF		PRIME+	103,344	2
3	LOAN COSTS		X	LOAN COSTS			172,161	144,028			8,466	3
4	GMAC MORTGAGE CORP		X	MORTGAGE	$39,218.00	07/2002	6,375,000	6,355,603	07/2037	6.6600	181,345	4
5												5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	VARIES	12/98	500,000		DEMAND	PRIME+	12,590	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	1,964,080	DEMAND	VARIES	92,449	7
8												8
9	TOTAL Facility Related				$39,218.00		$ 11,522,161	$ 8,463,711			$ 398,194	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,522,161	$ 8,463,711			$ 398,194	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 147,720	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 64,976	2
3. Under or (over) accrual (line 2 minus line 1).		$ (82,744)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 65,688	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ (17,056)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000	31,866	11
2001	64,976	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-011	NURSING HOME	$ 129,952.06	$ 64,976.03
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 129,952.06	$ 64,976.03

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	119,700	1997	$	1
2					2
3	TOTALS	119,700		$	3

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1997		$ 4,688,282	$ 170,483	27.5	$ 170,483	$	$ 1,015,794	4
5			1997		10,762	391	27.5	391		2,137	5
6			1998		95,000	3,455	27.5	3,455		17,129	6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MCKINLEY AVENUE LLC										9
10	OUTDOOR SIGNS			1997	13,284	483	27.5	483		2,636	10
11	REPLACE, REPAIR AND SEAL PAVEMENT			1998	6,754	468	15	450	(18)	2,025	11
12	REPLACE BLACK VALLEYS			1999	5,875	214	27.5	214		739	12
13	WALLCOVERING/CARPETING/WINDOW TMTS			1999	154,975	5,635	27.5	5,635		19,489	13
14	SPRINKLER SYSTEMS			1999	4,744	173	27.5	173		597	14
15	COURTYARD IMPROVEMENTS			1999	5,975	511	15	398	(113)	1,393	15
16	RESIDENT ROOMS/BATHROOMS - PAINTING			2000	13,710	498	27.5	498		1,226	16
17	FIRE ALARM CONTROL PANEL			2000	6,703	244	27.5	244		599	17
18	REMODELING - ARCHITECT FEE			2000	1,493	128	15	100	(28)	250	18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATIONS			2001	7,382	268	27.5	268		391	19
20											20
21											21
22					ADJ TO SL	(159)			159		22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,014,939	$ 182,792		$ 182,792	$	$ 1,064,405	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 289,826	$ 35,718	$ 22,830	$ (12,888)	3-15 YRS	$ 97,916	71
72	Current Year Purchases	30,373	6,074	1,519	(4,555)	3-15 YRS	1,519	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	582,943	59,481	59,481			303,910	74
75	TOTALS	$ 903,142	$ 101,273	$ 83,830	$ (17,443)		$ 403,345	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,918,081	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 284,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 266,622	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,443)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,467,750	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,489 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	2002 DODGE PICKUP TR	$ 281.46	$ 2,252	17
18					18
19					19
20					20
21	TOTAL		$ 281.46	$ 2,252	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 139,083	$		$ 139,083	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,752			29,752	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			173,444			173,444	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				113,703		113,703	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS, LAB, I.V. THERAPY Other (specify):	39-2					10,768		10,768	13
14	TOTAL			$		$ 342,279	$ 124,471		$ 466,750	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MCKINLEY COURT **#** 0042499 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 312,090	$ 411,365	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,970)	989,644	989,644	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,105	108,484	6
7	Other Prepaid Expenses	24,707	24,707	7
8	Accounts Receivable (owners or related parties)	1,506,822	1,618,013	8
9	Other(specify): ESCROW DEPOSITS	6,917	119,551	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,914,285	$ 3,271,764	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		827,400	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		231,657	15
16	Equipment, at Historical Cost	320,199	860,199	16
17	Accumulated Depreciation (book methods)	(214,236)	(1,746,947)	17
18	Deferred Charges	2,500	146,528	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	44,595	723,362	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 153,058	$ 5,825,481	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,067,343	$ 9,097,245	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,257	$ 291,257	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,672	39,672	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,147	20,147	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,332	4,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)		65,688	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	243,105	243,105	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 598,513	$ 664,201	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,619,256	344,824	39
40	Mortgage Payable		6,355,603	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,619,256	$ 6,700,427	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,217,769	$ 7,364,628	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 849,574	$ 1,732,617	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,067,343	$ 9,097,245	48

***(See instructions.)**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 91,474	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 91,472	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	758,102	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 758,102	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 849,574	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,515,637	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,515,637	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,075	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,075	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68,488	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68,488	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	2,789	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,789	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,587,989	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,042,852	31
32	Health Care	1,906,869	32
33	General Administration	1,679,885	33
	B. Capital Expense		
34	Ownership	651,406	34
	C. Ancillary Expense		
35	Special Cost Centers	466,750	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,829,887	40
41	**Income before Income Taxes (line 30 minus line 40)****	758,102	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 758,102	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,886	2,120	$ 53,463	$ 25.22	1
2	Assistant Director of Nursing	2,022	2,120	43,157	20.36	2
3	Registered Nurses	7,108	7,482	137,856	18.43	3
4	Licensed Practical Nurses	34,195	36,690	529,575	14.43	4
5	Nurse Aides & Orderlies	71,860	76,092	687,121	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,441	7,210	90,811	12.60	8
9	Activity Director	4,028	4,385	69,156	15.77	9
10	Activity Assistants	5,970	6,392	45,535	7.12	10
11	Social Service Workers	3,321	3,938	38,742	9.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,241	13,426	126,064	9.39	14
15	Cook Helpers/Assistants	13,867	14,397	92,851	6.45	15
16	Dishwashers					16
17	Maintenance Workers	1,907	2,382	36,073	15.14	17
18	Housekeepers	19,527	21,330	179,054	8.39	18
19	Laundry	13,907	14,238	91,702	6.44	19
20	Administrator	1,998	2,232	73,816	33.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,575	9,145	115,139	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,542	2,791	31,492	11.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,395	226,370	$ 2,441,607 *	$ 10.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	194	$ 9,928	1-3	35
36	Medical Director	96	28,260	9-3	36
37	Medical Records Consultant	18	1,230	10-3	37
38	Nurse Consultant	346	15,910	10-3	38
39	Pharmacist Consultant	216	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	49	2,802	11-3	44
45	Social Service Consultant	49	2,831	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	968	$ 62,161		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TOM MULLINS	ADMIN		$ 73,816
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,816

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 518,892
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 518,892

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		182,588
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 182,588

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 42,997
Unemployment Compensation Insurance		30,143
FICA Taxes		181,404
Employee Health Insurance		249,562
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,664
EMPLOYEE PHYSICAL EXAMS		3,497
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 511,267

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,135
Health Care Worker Background Check	350
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	37,156
TRUST/FRANCHISE/CONTRIB/ETC	5,200
LICENSES & PERMITS	1,000
DUES & SUBSCRIPTIONS	10,508
MGMT CO ALLOCATION	1,450
TRUST/FRANCHISE/CONTRIB/ETC	(5,200)
Less: Public Relations Expense	(18,289)
Non-allowable advertising	(15,417)
Yellow page advertising	(3,450)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,443

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,569
RELATED PARTY	8,049
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,618

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/1999	$ 3,281	3	$ 547	$ 1,094	$ 1,094	$ 546	$	$	$	$	$
2	PAINT/DECORATING	06/2000	2,965	3		494	988	988	495				
3	PAINT/DECORATING	06/2001	9,907	3			1,652	3,302	3,302	1,651			
4	PAINT/DECORATING	06/2002	2,840	3				473	947	947	473		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 18,993		$ 547	$ 1,588	$ 3,734	$ 5,309	$ 4,744	$ 2,598	$ 473	$	$

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. HEALTHCARE ASSOC. - $8640**

(3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,589** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,928	
	REPAIRS & MAINTENANCE		715	
			0	10,643
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		589	
	CONTRACTED LAUNDRY SERVICES		1,000	1,589
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,079	
	ELECTRICITY		89,640	
	WATER		9,647	
	CABLE TV - LOBBY		0	
			0	132,366
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		17,462	
	PAINTING & DECORATING		2,840	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		19,907	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		275	
	EXTERMINATING SERVICE		6,480	
	FIRE SERVICE		9,458	
	DEFERRED MAINTENANCE		1,667	
			0	
			0	58,089
7	**OTHER**			
	SCAVENGER		13,501	
	SECURITY SERVICE		0	13,501
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	28,260	28,260

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,230	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	15,910	
			0	
			0	18,340
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		3,872	
	SPEECH THERAPY SERVICES		2,666	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	6,538
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		9,185	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,802	
			0	11,987
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,831	
			0	2,831
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		38	38
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	518,892	518,892
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,550	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	163,038	
			0	182,588
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	18,289	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,417	
	EMPLOYEE WANT ADS	XIX F	2,135	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	10,508	
	LICENSES & PERMITS	XIX F	1,000	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,450	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,700	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	350	56,349
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,055	
	EQUIPMENT REPAIR & MAINTENANCE		4,349	
	OUTSIDE CLERICAL SERVICES		140	
	PENALTIES / OVERDRAFT CHARGES	VI 18	588	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		419	
	TELEPHONE		51,398	
	MESSENGER SERVICE		1,825	
			0	60,774

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	181,404	
	UNEMPLOYMENT COMPENSATION	XIX D	30,143	
	WORKERS COMPENSATION INSURANC	XIX D	42,997	
	HOSPITALIZATION INSURANCE	XIX D	249,562	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,664	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,497	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	511,267
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,396	5,396
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,569	
			0	
			0	3,569
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,892	2,892
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		125,321	125,321
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,751,230

MCKINLEY COURT
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	198,401	PATIENT MEALS	157470
LESS SALES TAX	(1,847)	ADD EMPLOYEE MEALS	0
NET FOOD	196,554	TOTAL MEALS/YEAR	157470
TOTAL PATIENT CENSUS	52,490	NET FOOD	196554
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	157470
TOTAL PATIENT MEALS	157470	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

MCKINLEY COURT
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										6,486,153	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		1,906,869	511,267	470,767	117,296	454,789	1,168,618	82,125	651,406		2,441,607
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	8,718		3,980			8,043		(20,741)		
	CABLE TV			0			0				
	CONTRACT NURSING										
	INTEREST INCOME							(68,488)			
	NET VENDING COMMISSIONS							(2,789)			
	EMPLOYEE PHYSICAL EXAMS		(3,497)				3,497				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(518,892)		518,892		
	O2 INCOME/ RENT INSURANCE						(114,211)	(1,075)	114,211		
	BAD DEBTS						0	0			
	DISCOUNTS LOST							0			
	ANCILLARIES	466,750							0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES/SALARIES REBIL	(63,404)	0	0	0	0	63,404	0	0		35,233
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(29,484)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		2,318,933	507,770	474,747	117,296	454,789	610,459	(19,711)	1,263,768	5,728,051	2,476,840
PER FINANCIAL STATEMENTS		2,318,933	507,770	474,747	117,296	454,789	610,459	(19,711)	1,263,768	758,102	2,476,840
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										758,102	

MCKINLEY COURT - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		54,750			54750			0	54900		
CENSUS DAYS		52,490			50567			1,923	50732		
OCCUPANCY %		95.87%			92.36%				92.41%		
SALARIES											
TOTAL General Services	8-1	525,744	9.54%	10.02	541268	10.38%	10.70	(15,524)	545474	11.59%	10.75
Social Services	12-1	38,742	0.70%	0.74	37820	0.73%	0.75	922	36378	0.77%	0.72
TOTAL Health Care and Programs	16-1	1,726,908	31.33%	32.90	1617200	31.01%	31.98	109,708	1375336	29.23%	27.11
Clerical & General Office Expenses	21-1	115,139	2.09%	2.19	126271	2.42%	2.50	(11,132)	130452	2.77%	2.57
TOTAL General Administration	28-1	188,955	3.43%	3.60	198632	3.81%	3.93	(9,677)	208091	4.42%	4.10
TOTAL Operation Expense	29-1	2,441,607	44.29%	46.52	2357100	45.20%	46.61	84,507	2128901	45.24%	41.96
ADJUSTED TOTALS											
Food	2-8	196,554	3.57%	3.74	197781	3.79%	3.91	(1,227)	188496	4.01%	3.72
Heat and Other Utilities	5-8	132,366	2.40%	2.52	133784	2.57%	2.65	(1,418)	126574	2.69%	2.49
Maintenance	6-8	116,560	2.11%	2.22	119482	2.29%	2.36	(2,922)	131702	2.80%	2.60
TOTAL General Services	8-8	1,045,187	18.96%	19.91	1048126	20.10%	20.73	(2,939)	1028164	21.85%	20.27
Administrative	17-8	92,075	1.67%	1.75	85782	1.65%	1.70	6,293	94792	2.01%	1.87
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	257,811	4.68%	4.91	170474	3.27%	3.37	87,337	202644	4.31%	3.99
Fees, Subscriptions, Promotions	20-8	15,443	0.28%	0.29	19989	0.38%	0.40	(4,546)	27460	0.58%	0.54
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.00%	0.00
License Fee-Other	Pg21	1,000	0.02%	0.02	1190	0.02%	0.02	(190)	200	0.00%	0.00
Clerical & General Office Expenses	21-8	315,806	5.73%	6.02	309324	5.93%	6.12	6,482	315751	6.71%	6.22
Employee Benefits & Payroll Taxes	22-8	511,267	9.27%	9.74	604858	11.60%	11.96	(93,591)	410787	8.73%	8.10
Payroll Taxes	Pg21	211,547	3.84%	4.03	210364	4.03%	4.16	1,183	188998	4.02%	3.73
W/C Insurance	Pg21	42,997	0.78%	0.82	38007	0.73%	0.75	4,990	32104	0.68%	0.63
Health Insurance	Pg21	249,562	4.53%	4.75	332738	6.38%	6.58	(83,176)	173213	3.68%	3.41
Inservice Training & Education	23-8	5,396	0.10%	0.10	1051	0.02%	0.02	4,345	7044	0.15%	0.14
Travel and Seminar	24-8	11,618	0.21%	0.22	13538	0.26%	0.27	(1,920)	12535	0.27%	0.25
Other Admin. Staff Transportation	25-8	2,892	0.05%	0.06	7540	0.14%	0.15	(4,648)	3623	0.08%	0.07
Insurance-Prop.Liab.Malpractice	26-8	164,777	2.99%	3.14	12176	0.23%	0.24	152,601	78665	1.67%	1.55
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	1,377,085	24.98%	26.24	1224732	23.49%	24.22	152,353	1153301	24.51%	22.73
TOTAL Operation Expense	29-8	4,339,429	78.72%	82.67	4087323	78.39%	80.83	252,106	3727260	79.21%	73.47
Real Estate Taxes	33-3	(17,056)	-0.31%	(0.32)	24486	0.47%	0.48	(41,542)	39600	0.84%	0.78
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,512,601	100.00%	**105.02**	5214397	100.00%	**103.12**	298,204	4705767	100.00%	**92.76**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2060661.4	37.38%	**39.26**	1857866.5	35.63%	**36.74**	202,795	1916083.9	40.72%	**37.77**

MCKINLEY COURT - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 5309 from Page 22 and -2840 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-301039
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-242273
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.